

Mission Critical—Health Care Jobs

- Michigan's largest private sector employer—546,000 jobs directly related to health care.
- Multiplier effect on jobs for other business, services and building renovations and construction.
- Over 1 million Michigan jobs related to health care.**
- Hospitals alone employ 219,000 people.
- Employees earn \$13 billion in wages, salaries and benefits.
- \$2.7 billion in federal, state and local taxes paid.


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Mission Critical—Community Benefits

- In FY 2009 \$2.6 billion provided in voluntary community benefit assisting nearly 9 million Michigan residents
 - \$675 million in health improvement through free/discounted clinics, immunizations, prescriptions, counseling, research and education
 - \$882 million in uncompensated care
 - \$317 million in charity care


Michigan hospitals: the heart of the community, safety net for underinsured and uninsured, local resource for health and wellness for individuals and business workforce


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Mission Critical—
Patient Safety and Quality


- MHA Keystone Center for Patient Safety and Quality (2003)**
 - Keystone ICU: 1830 lives saved, 140,000 hospital days avoided, \$300 million+ in health care dollars saved
- MIHospitalsInform.org website (2007)**
 - Public access to individual hospital quality and pricing data
- MHA Patient Safety Organization (2008)**
 - Clinicians confidentially report mistakes enabling identification and reduction of risks






Mission Critical—
Making Care Affordable

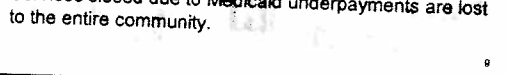
- Michigan hospital costs are 3.43% lower than national average (2009)
- Businesses saved \$538 million in employee health care costs compared to national average
- AHRQ: across all measures in hospital care MI performs the best
- Hospital efficiency and quality improvement are keys to ensuring access to affordable care.

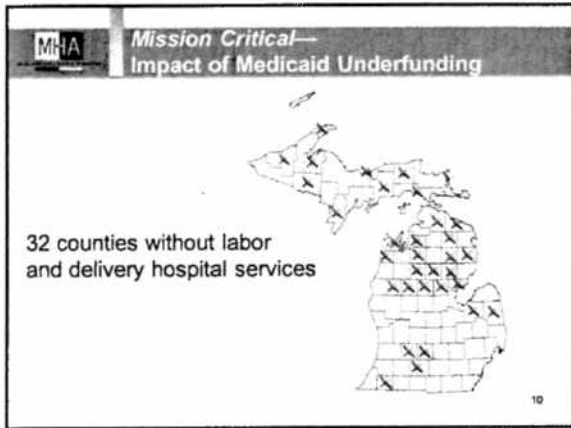


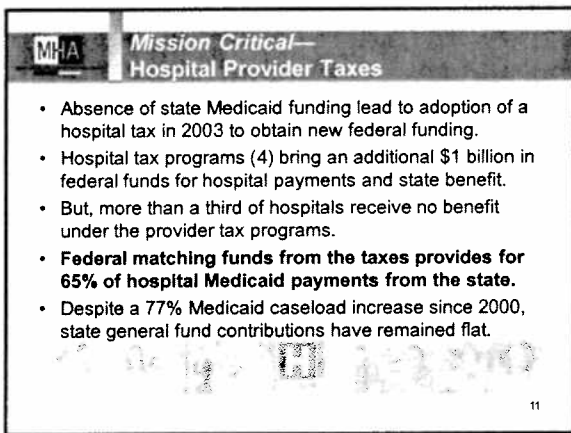


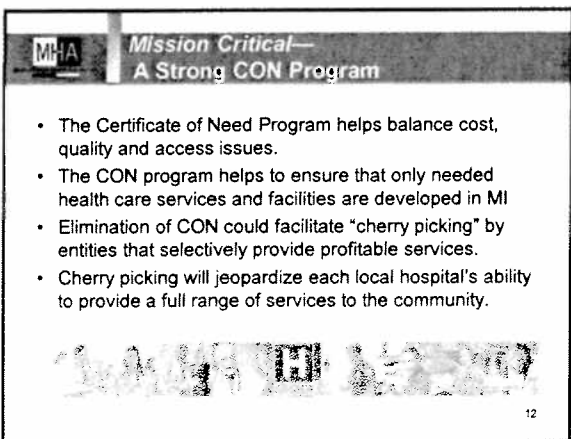
Mission Critical—
Medicaid Program


- Nearly 2 million people served by Medicaid— 1 in 5 state residents.
- 1.35 million Michigan residents have no health insurance.
- Today every GF dollar invested in Medicaid returns \$2.48 in federal matching funds.
- Every GF dollar cut from Medicaid results in \$3.48 in total losses for the program.**
- Underfunding by the government leads to cost shifting to private sector resulting in a "hidden tax" on businesses.
- Services closed due to Medicaid underpayments are lost to the entire community.












**Mission Critical—
Graduate Medical Education**


- GME investment pays for physician residencies—physicians in last stage of training
- These physicians work 60 hours per week, caring for the uninsured, and Medicaid and Medicare populations
- Annual pay ≈ \$48,000
- Physicians are more likely to settle in location where they do residencies
- **Great investment in high-tech, high-wage jobs and low-cost health care delivery**




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**Mission Critical—
Graduate Medical Education**

Graduate Medical Education Day
 Wednesday, February 16
 Special presentation by Dr. Richard Cooper,
 Professor of Medicine, University of Pennsylvania
**Physician Supply and the Myths of
Health Care Reform**
 12-1 pm
 Troppo Restaurant
 Lunch is complimentary



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Implementing National Health Reform

What will be expected of health care organizations?

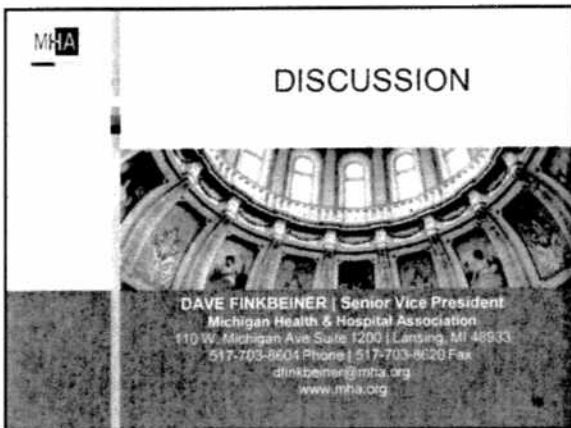
1. More integrated care
2. More at-risk payments
3. More accountability

HealthReform.gov

- MHA part of state's work on Health Benefit Insurance Exchanges
- Interested in early expansion of health benefit coverage to combat uninsured
- Working to fix Affordable Care Act, design regulations, protect hospital investment

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Presentation to House Health Policy Committee
David Finkbeiner
Michigan Health & Hospital Association
February 10, 2011



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MICHIGAN HEALTH & HOSPITAL ASSOCIATION

Advocating for hospitals and the patients they serve.

Timeline for Health Care Reform

Patient Protection and Affordable Care Act (H.R. 3590) and the Reconciliation Bill (H.R. 4872)

March 24, 2010

Color Code: Hospitals Insurance Coverage Other/Workforce Delivery System

2010

Expands the RAC program to include audits of Medicaid and Medicare Parts C and D.

Requires nonprofit hospitals to conduct periodic community needs assessments.

Prohibits all new health plans from denying children coverage based on pre-existing conditions.

Restricts use of annual limits on coverage.

Expands health professional loan repayment programs.

Eliminates the exception for physician-owned hospitals under the Stark law. Grandfathers in providers with Medicare agreements in place before December 31, 2010.

Extends rural outpatient hold harmless payments

Eliminates co-payments for preventive services and exempts preventive services from Medicare deductibles.

Provides a \$250 rebate to Medicare beneficiaries who hit the "donut hole."

Establishes interim high-risk pool for the uninsured.

Enhances elimination of Medicare fraud efforts.

Extends Section 508 hospital reclassification until September 30, 2010.

Establishes grants for clinics and hospitals to promote positive health behaviors in underserved areas.

Reduces Medicare inpatient, outpatient, IRF and psychiatric hospital payments by 0.25% and LTCH payments by 0.5%.

Provides tax credit of up to 35% of premiums to small businesses.

Extends coverage to those up to age 26 through parents' insurance.

Establishes health plan for companies with early retirees.

Establishes a National Health Care Workforce Commission to provide recommendations to Congress on aligning health care workforce resources.

Expands 340B drug discounts to outpatient drugs for children's hospitals, cancer hospitals, CAHs, SCHs and Rural Referral Centers.

Requires new health plans to cover preventive services.

Bans rescission practices and lifetime limits.

Establishes a Patient-Centered Outcomes Research Institute to conduct comparative effectiveness research.

Establishes an Innovation Center within CMS to test and evaluate various payment structures and methodologies.

2011

Adjusts Medicare payments according to study on OPPI — exempts cancer hospital costs.

Requires HHS Secretary to submit recommendations for reforming Medicare Area Wage Index.

Begins implementation of RUGs-IV payment changes for SNFs.

Prevents Medicaid payments to be used to pay for HACs.

Extends reasonable cost payment for clinical diagnostic lab services for rural hospitals with fewer than 50 beds to July 1, 2011.

Reduces Medicare inpatient, outpatient, SNF, IRF, psychiatric hospital, dialysis and LTCH payments by a "productivity adjustment" of 0.1%.

Requires all health plans to report annually on the share of premiums spent on medical care and rebate beneficiaries for excessive medical loss ratios.

Expands Medicaid eligibility to all people under 133% of FPL; voluntary until 2014.

Establishes voluntary payroll deduction long-term-care insurance program.

Redistributes unused residency slots, 75% of which must be used for general surgery or primary-care slots.

Provides scholarship and loan repayment funds for primary-care practitioners in National Health Services Corps area.

Establishes the Community Care Transitions Program for high-risk Medicare beneficiaries.

Requires HHS Secretary to give additional Medicare funds to lowest cost counties in the country.

Gainsharing demonstration project expires, but \$1.6 million in funds available until 2014.

2012

Reduces Medicare inpatient, outpatient, SNF, IRF, psychiatric hospital, dialysis and LTCH payments by a "productivity adjustment" of 0.1%.

Requires HHS Secretary to implement a "national quality assurance and performance improvement program" for SNFs and home health.

Extends FLEX programs through 2012.

Extends Medicare Dependent Hospital classification through September 30, 2012.

Increases funds for nursing and allied health professionals' loan repayment programs.

Reduces payments for hospitals with "higher-than-expected" readmissions rates for specific conditions; maximum reduction is 1%.

Establishes a Medicare VBP program that adjusts 1% of payment according to data collection and reporting on five medical conditions.

Begins voluntary ACO payment program.

Requires HHS Secretary to give additional Medicare funds to lowest-cost counties in the country.

2013

Reduces Medicare inpatient, outpatient, SNF, IRF, psychiatric hospital, dialysis and LTCH payments by a "productivity adjustment" of 0.3%.

Establishes quality and efficiency measures for PPS-exempt cancer hospitals to report. Noncompliance results in a reduction in the market basket update.

Establishes a pay-for-reporting program for freestanding and unit-based inpatient psychiatric hospitals.

Establishes a pay-for-reporting program for IRFs, LTCHS, hospices and psychiatric hospitals. Noncompliance results in a 2% reduction to market basket updates.

Begins Nonprofit Consumer Operated and Oriented Plans (CO-OPs).

Establishes a 2.9% excise tax on medical devices.

Simplifies administrative burdens by standardizing electronic exchange of health information.

Begins voluntary bundled payment pilot program. Includes payment for 10 conditions.

Expands Medicare VBP program to include more conditions and efficiency measures, including spending per beneficiary. Adjusts payments by 1.25%. Includes an appeals process.

2014

Reduces inpatient, outpatient, IRF, LTCH and psychiatric hospital payments by 0.2%

Begins reduction in Medicare DSH payments. Reductions are tied to coverage

Begins reduction in Medicaid DSH payments. Reductions are not directly triggered by coverage targets.

Begins Health Benefits Exchanges.

Bans coverage refusal based on pre-existing conditions for all people, and bans lifetime and annual limits.

Requires states to cover all former foster children up to age 26 through	Provides tax credit up to 50% of premiums to small businesses.	Provides 100% federal funding for costs associated for Medicaid "newly eligibles" through 2016.	Begins individual mandate for health insurance.
Grants for clinics and hospitals to promote positive health behaviors in underserved areas expire.			
Expands readmission policy to include more conditions. Maximum reduction in payments to hospitals with higher-than-expected readmissions rate increases to 3%.	Requires all eligible professionals to participate in the Physician Quality Reporting Initiative. Provides a 0.5% bonus to those reporting properly, and deducts funds from those that use substantially more resources than their peers.	Allows Medicare VBP program to adjust payments by 1.5%.	Provides hospitals in the top 25 th percentile of certain HAC rates with a 1% payment reduction.

2015

Reduces Medicare inpatient, outpatient, IRF, LTCH and psychiatric hospital payments by 0.2%.	Extends Rural Community Hospital Demonstration Project through 2015.
Provides 100% federal funding for costs associated for Medicaid "newly eligibles" through 2016.	
Establishes Independent Payment Advisory Board to submit recommendations to Congress on reducing Medicare spending. Hospitals receiving productivity adjustments are exempt from board proposals through 2019. CAHs are not exempt.	
Allows Medicare VBP program to adjust payments by 1.75%.	Expands bundled payment program according to HHS Secretary's plan.

2016

Reduces Medicare inpatient, outpatient, IRF, LTCH and psychiatric hospital payments by 0.75%.	
Provides 100% federal funding for costs associated for Medicaid "newly eligibles" through 2016.	Provides states with an FMAP increase of 23% to accommodate transition from CHIP to the exchanges. Increase occurs through 2019.
Allows Medicare VBP program to adjust payments by 1.75%.	

2017

Reduces Medicare inpatient, outpatient, IRF, LTCH and psychiatric hospital payments by 0.75%.

Allows employers with more than 100 employees to enter the exchanges at the discretion of the state.

Reduces federal funding for costs associated with Medicaid "newly eligibles" to 95 percent of costs.

Allows HHS Secretary to expand VBP pilot program for IRFs, LTCHs, psychiatric hospitals, PPS-exempt hospitals and hospices.

2018

Reduces Medicare inpatient, outpatient, IRF, LTCH and psychiatric hospital payments by .075%.

Reduces federal funding for costs associated with Medicaid "newly eligibles" to 94%.

2019

Reduces Medicare inpatient, outpatient, IRF, LTCH and psychiatric hospital payments by 0.75%.

Reduces federal funding for costs associated for "newly eligibles" in Medicaid to 90%.

Note: Unless otherwise noted dates are for the calendar year. For example, federal fiscal year 2012 begins October 1, 2011.

Glossary

CAH — Critical Access Hospital
 CMS — Centers for Medicare & Medicaid Services
 DSH — Disproportionate-Share Hospital
 FMAP — Federal Medical Assistance Percentage
 FPL — Federal Poverty Level
 HAC — Hospital-Acquired Condition

IRF — Inpatient Rehabilitation Facility
 LTCH — Long-Term-Care Hospital
 PPS — Prospective Payment System
 RAC — Recovery Audit Contractor
 SCP — Sole Community Hospital
 VBP — Value-Based Purchasing

